State of Rhode Island
REPORT OF SPECIFIC PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8084

DWC No. _____

Insurer File No. _____

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:

☐ **LOST TIME** ☐ **NO LOST TIME** ☐ **FEDERAL JURISDICTION**

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number

5. CLAIM INFORMATION:

Injury date _____ Incapacity date (if appropriate) _____

Average Weekly Wage (including OT) _____ Weekly Specific Rate _____

Specific paid by: ☐ Court Order Date: _____ Number: _____ **OR** ☐ Agreement of the Parties

Description of Injury/Specific: _____

Attorney Fee: _____

6. SPECIFIC PAYMENT INFORMATION:

Indicate Payment Type	Body Part	Percent of Loss	Number of Weeks	Amount Paid	Date Paid
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					

Hearing Loss			Total/Partial Deafness		Number of Weeks	Amount Paid	Date Paid
Left Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			
Right Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			

Employee Signature: Date:	Employer/Insurer Signature: Date:
(Not required for Court Order)	

For instructions visit our web site: www.dlt.state.ri.us/wc